AUBURN BAY DENTAL

HEALTH HISTORY

Name: _____

Yes No Are you currently being treated by a physician? For what? _____
Date of last medical exam: _____
Physician name and phone number: _____

Yes No Are you taking any medications, non-prescription drugs, or herbal supplements?

If so, please list: Reason for taking them:

_____ _____

_____ _____

Yes No Do you have any allergies? If so, please list: _____
Yes No Have you ever been recommended to take antibiotics prophylaxis before dental treatments?

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Yes No Autoimmune Disease
Yes No Chest Pain/Angina
Yes No Heart Attack
Yes No Heart or Blood Pressure Problems
Yes No Heart Murmur
Yes No Rheumatic Fever
Yes No Prosthetic Heart Valve
Yes No Pacemaker
Yes No Breathing or Sleep Problems (Sleep Apnea, Snoring, Sinus)
Yes No Shortness of Breath or Asthma
Yes No Lung DIsease
Yes No Tuberculosis
Yes No Stomach Ulcers
Yes No Steroid Therapy
Yes No Radiotherapy, Chemotherapy
Yes No Psychiatric Treatment/ Depression/ Anxiety/ ADHD

Yes No Glaucoma
Yes No Diabetes
Yes No Kidney Disease
Yes No Thyroid Disease
Yes No Stroke
Yes No Seizures
Yes No Epilepsy
Yes No Osteoporosis
Yes No Prosthetic or Artificial Joint
Yes No Arthritis
Yes No Bleeding Problems/ Disorder
Yes No Cancer
Yes No AIDS/ HIV Infection
Yes No Hepatitis/ Jaundice/ Liver Disease
Yes No Smoke or Chew Tobacco
Yes No Drug/ Alcohol Dependency

Yes No Are there any conditions or diseases not listed above that you currently have or have had?
If so, please list: _____
Yes No For women only: Are you currently pregnant or nursing? _____

To the best of my knowledge, the above information is correct. I will inform _____ Dental of any change in my health and/or medication.
Patient/ Guardian Signature:_____ Date:_____